Governor's Commission
To Review and Advise on the Implementation of
New Hampshire's Medicaid Care Management Program

MINUTES

October 2, 2014
1:00 – 4:00pm
Legislative Office Building Room 301-303
Concord, NH

Welcome and Introductions

The meeting was called to order by Commissioner Mary Vallier-Kaplan, Chair, at 1:05pm. Present in addition to Commissioner Vallier-Kaplan were Commissioners Donald Shumway, Nicholas Toumpas, Roberta Berner, Kenneth Norton, Yvonne Goldsberry, Wendy Gladstone, Jo Porter, and Susan Fox. Also in attendance were Kathy Sgambati and Brittany Weaver from the Office of the Governor.

Absent: Commissioners Douglas McNutt, Tom Bunnell, and Gustavo Moral.

Commissioner Vallier-Kaplan welcomed everyone and invited the Commissioners and the public to introduce themselves, and asked for those within the public who are representing others, e.g. consultants or attorneys, to identify who they are representing.

Commissioner Vallier-Kaplan explained the primary and unique purpose of the Commission is to engage with the public on issues surrounding the Medicaid Care Management (MCM) Program. The meeting agenda began with an overview of the Commission and an explanation of how during the meeting, if time allows, each section will contain an opportunity for questions. Attendees were encouraged to focus on higher-level questions and common issues, as opposed to individual concerns that should be raised first to an individual's MCO and then to DHHS. The first half of meeting contains feedback received since the last meeting, updates and new issues, new implementations, etc. After the break, the meeting moves into the area of education and discussion, and today will focus on principles formulated by the Commission to guide DHHS' work as it moves forward into Step 2 MCM implementation. These principles were posted on the Commission's website with the meeting agenda and were shared in hard copy during meeting. Questions and time for a public listening session will follow.

Commissioner Shumway thanked the three panelists who presented during the September MCMC meeting: Steve Ahnen, President of the New Hampshire Hospital Association, Clyde E. Terry, Chief Executive Officer of Granite State Independent Living, and Karen Boudreau, MD, Chief Medical Officer for Well Sense Health Plan.

Minutes of the September 4, 2014 Meeting

There are no corrections to the minutes of the September 4, 2014 meeting. Upon a motion duly made and seconded, the minutes of the September 4, 2014 meeting of the Commission are approved.

Previous MCM Commission minutes, handouts, and recommendations are posted on the website for DHHS and the Governor's Office if you are interested in more details.

DHHS MCM Update

Commissioner Vallier-Kaplan introduced Commissioner Toumpas for an update on MCM implementation. Commissioner Toumpas introduced a presentation that will be updated and refined each month to provide a standard MCM update. The presentation focuses on enrollment updates, the Key Program Indicator (KPI) report, Step 2 MCM planning and implementation, other updates, and feedback on previous Q&A from the Commission and the public.

Enrollment: The MCM program began on December 1, 2013 and has been underway for 10 months. The principles of the program include whole person management and care coordination, increasing the quality of care, payment reform opportunities, budget predictability, and purchasing for results and delivery system integration. As of October 1, 2014, 133,716 people were enrolled in the MCM program. The 22,090 enrolled in Medicaid but not enrolled in MCM consists of several groups: those who are not mandatory and therefore cannot be mandated into the program, those who have opted out of the program, those who have been deemed eligible for the New Hampshire Health Protection Program (NHHPP), and those who have enrolled in the MCM program but have not yet selected a plan and therefore remain in fee-for-service (FFS) until they do so. DHHS has seen an enrollment uptick from the middle of August until the beginning of October, which reflects the NHHPP population entering the system. In terms of MCM program enrollment by plan, Well Sense has 72,672 members enrolled and New Hampshire Healthy Families has 61,044 members enrolled, which reflects the transition of all Meridian Health Plan members upon their exit at the end of July. Low income children ages 0-18 make up the majority of MCM program population, as it does in the Medicaid program itself. Roughly 70% of the Medicaid population is low income women and children, who are clearly reflected in the health plans' enrollment numbers. Other areas include non-MCM enrollees and NHHPP enrollees who have not yet selected a plan, as well as the others who have not yet opted into program.

Commissioner Vallier-Kaplan opened the meeting to the Commissioners for comments and/or questions on MCM enrollment numbers. None recorded.

October Key Indicators Report: Commissioner Toumpas reviewed the Key Performance Indicator (KPI) report released by DHHS, which is part of the overall Medicaid quality program. This report was posted on DHHS' website and sent to Commission prior to the meeting. The report is a standard document that DHHS uses to monitor performance of the MCM program. The report contains a number of areas in which DHHS is not fully confident in the current data, and is therefore making changes. These areas are highlighted within the report. Each month the report will follow the same format, building off baseline data from the first few months of the program. The KPI report has also shown things that result in DHHS action to make improvements. If something is troubling, DHHS will act upon it. Many indicators are monthly, but some are quarterly and annually. There is also a user guide embedded in document as a tool for those who review. The metrics contained within the report include:

1. Access & Use of Care
2. Customer Experience of Care
3. Provider Service Experience
4. Utilization Management
5. Grievance & Appeals
6. Preventative Care
7. Chronic Medical Care
8. Behavioral Health Care
9. Substance Use Disorder Care
10. General

Follow up on Horn Report: Commissioner Toumpas addressed an open issue raised during the September meeting, which is the Horn Report. Details on how the findings of the Horn Report are being implemented into Step 1 MCM and will be considered during Step 2 planning and design. The Horn

Report provides valuable input from members which may not be captured by other means. Information captured was from a small sample yet represents an important element for consideration in future designs. DHHS is focusing on four key areas as follow-up lessons learned from the Horn Report:

1. Experience with Care Management: The Department will provide additional information to assist members in selecting an MCO.
2. Access to Care: The Department is currently engaged in a review of prior authorization processes.
3. Quality of Care and Care Management: The Department will continue to emphasize the importance of shared decision making and care coordination in the MCM program.
4. Information Needs: The Department will reinforce the importance of mailed and printed materials for members.

Follow Up on other issues: Commissioner Toumpas followed-up on other issues raised by the Commission in September. Specifically, DHHS located data errors in the area of Emergency Department utilization within the KPI report. The previous data showed a higher level of utilization than what was accurately being reported, however this has been corrected. Another issue raised was how the KPI report would be made available to providers. The KPI report can be found at: http://www.dhhs.nh.gov/ombp/quality/index.htm. The Department is also compiling a mailing list to inform stakeholders when a new report is created. To be added to this list, stakeholders should e-mail MedicaidQuality@dhhs.state.nh.us with the subject line "Key Indicators Mailing List."

Notable Results of Key Indicators: For each major domain, Commissioner Toumpas reviewed the notable results. The first domain focuses on access and use of care. 23% of transportation requested rides were not approved or not delivered. While this may represent an appropriate utilization, DHHS has determined that the measure does not provide all the necessary information to draw data-based conclusions about transportation requests. We do not know if the driver did not show up, if the client did not show up, or if a change was not communicated. Therefore, DHHS needs to drill down further into the data and has new, approved measures and data requested from MCOs. The second piece focuses on the State's External Quality Review program. This is a detailed evaluation conducted by an external organization to ensure accurate measuring and information collection is occurring and is able to be reported out.

Within the customer experience of care section, data indicates that member calls are being answered quickly and within contract standards. Member call times decreased in August due to the completion of the Meridian Health Plan transition. DHHS is currently investigating the measure to determine consistent reporting between both MCOs. For example, one MCO had a higher upward call trend in July, so they hired additional call center staff. For the provider service experience section, claims are being paid accurately and within contract standards, assuming claim was submitted properly by the provider. Pharmacy claims processing was low and is still below contract standards, however has improved. Hold time trends continue and DHHS is investigating these measures across both plans. In terms of utilization management, service authorization requests and benefit decision rates have increased. This is being driven by an increase in denials for inpatient surgical admissions, physician/medical services, private duty nursing, and personal care attendant services, and is being seen primarily within one MCO. Generic drug utilization is increasing and having a positive impact. In terms of grievance and appeals, grievances continued to decrease while the number of appeals has increased. This increase is driven exclusively by a 119% increase in pharmacy appeals, primarily related to a change in one MCO's pharmacy utilization management, and DHHS is currently reviewing pharmacy service authorizations.

In terms of behavioral health care, members seeing providers within 7 days for a follow-up appointment after hospitalization for mental illness is the focus of a Performance Improvement Project that is outlined in the MCM contract. Performance Improvement Projects typically require 2-3 years to complete. DHHS

will measure interim improvement as well as adherence to rigorous Center for Medicare & Medicaid Services (CMS) protocols focused on design, implementation, and outcomes.

Q&A on Key Indicators: Commissioner Vallier-Kaplan opened the meeting to the Commissioners for comments and/or questions on the Key Performance Indicator (KPI) Report. Commissioner Porter requested for DHHS to report out on the findings, if available, and/or agenda items of focus groups held in October with respect to the KPI report. Commissioner Norton asked about a specific reference to providers on page 34 of the KPI report. The report text references "doctor" while the slides presented reference "provider" within 7 days of discharge. DHHS recognizes the difference and implications and will clarify if the intent of the language is to read "provider" or "doctor". Also, Commissioner Norton noted that the narrative in the KPI report is inaccurate to say that a low or falling number of follow-up appointments in 7 days indicates a successful discharge; this places all responsibility on the hospital, but could also be the lack of sufficient supports in a community that result in a readmission process. This is important to note within the report, therefore DHHS will take this back as follow-up. A hospital cannot do discharge planning without collaborating and coordinating with whom this discharged individual is to go; process would not work if both parties were not involved. Commissioner Norton explained how we often point to this as being a failure when in reality it is lack of resources.

Commissioner Goldsberry suggested that the language of the KPI report could focus more on care transitions instead of discharge planning. This process is done in the best interest of the client and almost always requires coordination amongst hospitals, community providers, and other resources. Commissioner Norton commented that he believes this is an ongoing contract piece for the community mental health centers (CMHCs). This isn't a new performance indicator, but the measurement piece is. Commissioner Goldsberry suggested for a future panel presentation to the MCMC to look at notion of care transitions and have a more integrated panel across multiple types of services to call out issues within transitions, e.g. hospital, nursing home, community provider. Commissioner Toumpas agreed and suggested a particular focus area between primary care and behavioral health.

Commissioner Shumway referred back to the notable results for provider service experience within the KPI report and how claims are paid accurately. The question is if embedded in this data is a subset of providers who are not getting paid. The Commission has heard from therapy providers on this issue, so it needs to know if this issue has been resolved. Commissioner Toumpas explained how these providers would be a subset not reflected in this report because when claims come in they (1) get paid because they are considered "clean" claims, (2) some data that is missing or there are questions on the claim that therefore puts it into a pending status, and (3) a claim is denied. Further data is needed to determine, for example, how long a claim stays in a pending status, why it is denied, etc.

Commissioner Goldsberry explained how the current contract standards are set to a best practice, but perhaps they could be set to a large quality document or could be set against aspirational numbers for future improvement standards. In an upcoming session of the MCMC, DHHS will provide an update on the overall quality management system and that is being created to show ranges and how the system will flag things that are out of range. Commissioner Norton asked about projecting what the benchmarks will be within this system and where to make these comparisons. The description describes it as a standard industry approach, but do we have a gauge nationally about each of areas being measured? LisaBritt Solsky, DHHS Medicaid Program, explained that certain measures, e.g. Emergency Department (ED) utilization, it is an example of a measure without parameters because DHHS will be looking at New Hampshire exclusively. It is unfair to compare to ED data to another state because will be different. This is an example of where we need to see a trend so we can figure out/dig into specific cases.

Commissioner Toumpas added that DHHS, the New Hampshire Hospital Association, and both MCOs have met to talk about ED usage. This was spurred by DHHS' requirement to submit a state plan

amendment (SPA) regarding non-payment of non-emergency use of the ED. This presented a number of challenges in terms of implementation, e.g. a number of people came out and said it was problematical and DHHS agreed. Steve Ahnen convened a discussion between this group to look at best practices, and there are promising things being done within the hospitals in the State. This group can also look at practices in other states in which both MCOs operate as well, for example the State of Washington had some success in limiting inappropriate use of ED through better education.

Commissioner Porter suggested looking at rates within the fee-for-service (FFS) population as a benchmark. Not all measures are appropriate for this but New Hampshire FFS data may be a benchmark the can be used to generate a trend from a previous period. DHHS confirmed that this suggestion is being looked at. Commissioner Vallier-Kaplan added that a standard industry approach may not necessarily mean using a national benchmark, but using an approach to benchmark, whether it is previous state data or national. Overall, Commissioner Vallier-Kaplan acknowledged the format of presenting the report and its follow-up items from the last meeting and transitioned to the next agenda topic.

DHHS Step 2 MCM Timeline Update

Commissioner Toumpas provided a review of current timeline of Step 2 MCM. At the time of the meeting, the current timeline included three phases: phase 1 to include mandatory populations by January 1, 2015, phase 2 to include CFI and NF services by April 1, 2015, and phase 3 to include DD, ABD and IHS with a TBD implementation date. Commissioner Toumpas formally announced that DHHS will postpone the mandatory populations and the CFI and NF services, and that a new timeline will be announced at the MCM Commission meeting scheduled for November 6, 2014. DHHS received significant stakeholder feedback over the course of the summer, so we listened and made a change. Commissioner Toumpas presented a number of reasons that provide context for this delay of Step 2 MCM, which include challenges to implement a 1915 waiver for Mandatory enrollment, two separate dates for Mandatory and CFI and NF services created potential challenge for clients, the MCOs have seen significant growth in populations being served, driven by MAGI, Meridian Health Plan transition and NHHPP implementation. There were also concerns raised since implementation on key processes for Service Authorizations, Prior Authorizations and Transportation services. DHHS wants to expand opportunities for substantive discussions; therefore, DHHS has developed a detailed framework for Step 2 Concepts built on the prior SIM work, Stakeholder feedback and input, and the draft principles from the Commission and other sources. DHHS will present these concepts at the next MCMC meeting in November. Commissioner Toumpas affirmed the commitment from both DHHS and the Governor that we will move forward with Step 2 MCM, but not until we are ready to do so. As such, mandatory enrollment will not occur on January 1, 2015 and enrollment of CFI and NF services will not occur on April 1, 2015, and a new timeline will be presented to the Commission on November 6, 2014.

Q&A: Commissioner Vallier-Kaplan opened the meeting to the Commissioners for comments and/or questions on the Step 2 MCM timeline and reiterated how although target dates were necessary, DHHS has demonstrated that it will not move forward until it is ready and can do so well. Listening sessions are a common tool, but people often do not do anything with their results. In this case, DHHS used the results and Commissioner Vallier-Kaplan commended DHHS and its staff for listening and making an impact on what was heard. This truly shows the connection between the government and the public. Commissioner Toumpas agreed and explained how the issues that this population faces are more complex than Step 1 and there are still areas of the population who are struggling because we have been unable to provide rate increases for a number of years. Coordination and care management is appropriate to do for these individuals, but we need to make sure we are doing it right and strike the balance between the MCOs, the Governor's office, and the public in doing so. We truly have listened and while this is the right decision, DHHS continues to work on its plan and will come back to the Commission in November to review it.

Commissioner Shumway also thanked the MCOs as they are always investing in the next step and must have the program follow along; predictability is key to their efficiency. Commissioner Norton agreed and explained that while everything is laid out well, it is summed up by the last line: not ready. He also asked for an update on DHHS' application for a CMS State Innovation Model (SIM) Round Two Model Design application. Commissioner Toumpas explained how DHHS expects the results of its application by the end of October 2014, per the funding opportunity announcement (FOA), but this is subject to change.

Commissioner Goldsberry thanked DHHS for the summary and for touching on resolving outstanding issues from Step 1. This is a significant concern in terms of adding more types of providers in Step 2 and their ability to do this work, given the challenges that hospitals faced in Step 1. Hospitals are still struggling, and DHHS needs to help resolve these issues to set Step 2 up for success. Commissioner Toumpas agreed and explained how DHHS is looking for ways to streamline and standardize certain things based upon lessons learned from Step 1.

DHHS NHHPP Update

Commissioner Toumpas provided an update on the implementation of the New Hampshire Health Protection Program (NHHPP). As of October 1, 2014, 18,612 people have been enrolled into the NHHPP. This is a remarkable number. When you consider the analysis shows about 50,000 eligible citizens over the course of 7 years, the fact that we are already approaching half in 3 months is remarkable. Of this total number, 17,151 are in the Alternative Benefit Plan (ABP), 1,214 of Medically Frail are in the ABP, and 247 of Medically Frail are in standard Medicaid. The main difference between the ABP and Medically Frail is having the ability to receive long term services and supports (LTSS). SUD and chiropractic services, however, are available as part of the ABP. In terms of the HIPP program, 826 are potential HIPP, 6,562 are enrolled in Well Sense, 5,983 are enrolled in NHHF, and 5,241 are in fee-for-service (FFS) as they are not yet enrolled in a plan.

The Premium Assistance Program is the third phase of the NHHPP. DHHS has a target submission date for the Premium Assistance 1115 Waiver of December 1, 2014, per SB 413 requirements. It is essential that DHHS receives CMS waiver approval by March 1, 2015 or NHHPP will end June 30, 2015. The transition of this population from an MCO to a qualified health plan (QHP) on the marketplace is targeted for January 1, 2016. Public notice for this waiver began on October 1, 2014 and DHHS already briefed the Joint Health Reform Oversight Committee and Medical Care Advisory Committee. There are public hearings for this waiver on October 8, 2014 and October 20, 2014. All information for this waiver can be found here: http://www.dhhs.nh.gov/pap-1115-waiver/.

Unrelated to the Premium Assistance 1115 Waiver, DHHS submitted its Building Capacity for Transformation 1115 Waiver application to CMS at end of May 2014. Since that time, DHHS continues to have discussion with CMS on the transformations and initiatives included in the application. Recent guidance from CMS requires DHHS to rework certain portions of the waiver and demonstrate how the waiver will change delivery and payment systems in the State.

Public Comments and Questions on MCM Implementation Update by DHHS

Commissioner Vallier-Kaplan opened the meeting for public comments and/or questions.

Chris Dornin, writer for The New Hampshire Challenge, Inc, asked for clarification on the delayed Step 2 MCM timeline. Commission Toumpas explained that both the January 1, 2015 date for mandatory enrollment and the April 1, 2015 date for CFI and NF services have been postponed. DHHS will present an updated timeline for both phases on November 6, 2014. Since DHHS has not identified a date for DD, ABD, and IHS waiver services, this date still remains TBD.

Commissioner Vallier-Kaplan announced a meeting break until 2:40 pm. The scheduled presentation on network adequacy was postponed until a future meeting.

DHHS MCM Step 2 Stakeholder Meetings Update

Commissioner Vallier-Kaplan introduced Lorene Reagan, DHHS, to provide an update on the ongoing Step 2 stakeholder forums. Lorene Reagan thanked the Commission for the opportunity to give an update on the stakeholder input process and next steps in Step 2 MCM planning. To date, DHHS has engaged hundreds stakeholders across the state. To remind or inform those who have not attended, the 120-day stakeholder input process period began on July 15, 2014 and will end on November 15, 2014. The first half of the time period is being used to solicit input on Step 2 planning for Phase I, Phase II, and Phase III of the program. Two additional forums were added at People First of New Hampshire and Hillsborough County Nursing Homes. DHHS hosted 27 forums across the state and engaged upwards of 700 people. The forums were held at various times of day and in various formats, including video conferencing and a Saturday session, to reach the maximum number of stakeholders.

During the forums, the following three questions are being asked and discussed:

1. What works for you now in terms of how your Medicaid services are provided and what should be continued?
2. What are the "lessons learned" during Step1 implementation that we should consider for Step 2 planning and implementation?
3. What do you think should be included in a Step 2 Quality Strategy? What are the most important things that should be measured to make sure that the MCM Program is working well?

DHHS received lots of great feedback and questions that are still being summarized to be posted on the Department's MCM website. A schedule for the second set of stakeholder forums will be posted along with FAQ documents from the first set of forums as well. Throughout the forums DHHS has received input to make decisions around the timeline and the formulation of concept plan that will be available in early November, per Commissioner Toumpas' update. Lorene Reagan explained that as we move forward and bring a high-level concept plan to various stakeholders, the Governor's office, CMS, and the public, we hope and believe that you will see many of the pieces of input received, a focus on philosophy, and an understanding that change needs to happen in way that most can understand. This plan will be presented in a similar framework as the updates presented to the Commission each month.

Public Comments and Questions on MCM Step 2 Stakeholder Meetings

Commissioner Vallier-Kaplan opened the meeting for public comments and/or questions. None recorded.

Principles for MCM Step 2 Developed by the Commission

Commissioner Vallier-Kaplan introduced Commissioner Fox to discuss principles developed as the Commission's benchmark and defines what is most important in their role to move into next phases of MCM. Commissioners McNutt and Fox spent a significant amount of time developing these principles under tight timeframes. This is the first time the Commission has reviewed the principles.

Commissioner Fox reviewed the set of 16 principles and the vision and mission statements that were reaffirmed during the SIM Round One Model Design process. The Commission feels that the values developed during SIM Round One and the State Health Care Innovation Plan should be used as they were developed by large group of stakeholders. Commissioners McNutt and Fox looked at a wealth of resources out there including CMS, Truven Analytics, SIM Round One, the Governor's feedback to the

Commission, feedback from stakeholder forums, and tried to pull together these resources in a way that was not a massive list. The Commission hopes and feels that all of these things are represented in the set of principles presented. These principles have been reviewed by DHHS and the Governor's office, and feedback has been incorporated from these sources. Commissioner Fox asked if the principles make sense to the public and the Commissioners who reviewed them.

Discussion: Commissioner Vallier-Kaplan opened the meeting to the Commissioners for comments and/or questions on the principles.

Commissioner Porter referred to principle #3 and recommended separating it between the two very strong legal parameters and the notion of an integrated system, which seems like its own principle. Commissioner Goldsberry agreed and also referenced principle #9 that discusses payor integration; perhaps the second half of #3 goes to #9. When we use the term integrated in the principles, this term could also mean transitions between; want to include care transitions mentioned in #9. There is also concern around the connection between contract standards and quality monitoring of the data that we have. We know it links, but we need to make sure that it links. Somehow we connect this notion with quality, but it should be embedded and embraced in contracts as well. The fear is that a disconnect could be made at some point; if not explicitly stated, contract standards and quality metrics could misalign.

Commissioner Porter asked about parameters and what the Commission will learn next month from DHHS. DHHS previously reviewed policies and rules that dictate what is and is not possible within MCM. For examples, there are parameters of cost differentials that need to be met to be in community or nursing home care. Does it make sense in the principles, e.g. #4, to reference that the ideal scenarios under MCM may have implications for some of these rules or vice versa? Are there caps to what these could look like based upon legislation? Payment structures have to take into account that there are legislative potential caps on what is possible based on these parameters. Commissioner Fox agreed that it is a great question to address as this moves forward; unsure if this can be a principle or not, but something to raise.

Commissioner Toumpas explained how principles are meant to be guidelines so that as you are making decisions and developing criteria for the program, or determining how to assess quality, these principles can guide the design of these things. Principles should be equated to guardrails on the highway. Some of these principles are more down in the weeds in terms of the details. They are design criteria that DHHS needs to look at, but might not be best classified as principles. We know that we want to have a system that emphasizes self-determination, choice, etc., and then you look at developing the details of this system. Principles are typically fewer in number. What Commissioner Porter raised in terms of cap is not a principle but a more detailed design element. The point is that there are these limitations in statute that will have implications for how the final design looks, and from a principle standpoint these payment structures need to be developed within parameters. If DHHS looks at something they want to do and a statute is a barrier, then we go off and determine how to move this barrier. Conversely, we may need a statute to do something that we want to meet the goals of the program. These are all design elements for DHHS to focus on moving forward.

Commissioner Goldsberry raised the issue of specificity within the principles and agreed with Commissioner Toumpas about how to formulate core principles and add an explanation. The Commission may feel compelled to keep this level of detail within the principles to remind everyone and the Governor of why the principles are in place. As a Commissioner, we need to decide how to maintain specificity as an explanation or a rationale behind the principles.

Commissioner Vallier-Kaplan introduced the possibility to not call them principles. This term has been in place from the start, but the Commissioner could explore something else, e.g. implementation guidelines.

Whatever they are called, they will be a tool for the Commission and we need to answer the question about what we are going to use these items for. Perhaps they can be organized better, e.g. by overall program, payment structure, development process, etc. How to organize them in a new framework to look at them in a certain way is important. One thing the Commission has tried to do and has done well and consistent with behavior is to lay things out in advance and be true to them. Use them all and respect not going outside the boundaries. That is the importance of this exercise, in terms of setting expectations. A lot of the concepts in these principles come from guidance from CMS guidance on 1115 or 1915(b) waivers. The best use for this information is not only for the Commission and DHHS, but also for the MCOs. The Commission has learned that when we are all using different frameworks about the same thing, we bump into each other, are less effective and confuse the public. Let us all use and agree upon this information before we move on.

Commissioner Toumpas added that if you look at these principles, a couple things are evident. Several of these principles deal with a process for development, e.g. state roll out and deliberate planning. This is not a principle. It is a part of an implementation plan. A principle could be the MLTSS reference in #3. This is not design criteria. DHHS asked the Commission to bring these principles up to a higher level and less focus on the design of the program.

Commissioner Shumway labeled this conversation as useful and clearly identifies something the Commission can use, but the question is how we use it. What is the process work that goes into the development of service delivery implementation and high-level standards? Would it be a worthwhile to take an additional 30 days to look at document from this point of view? We need to see it as an operating tool. The remaining Commissioners agree with this plan to further review the principles and determine how they fit in with DHHS' Step 2 MCM process moving forward. It is important to determine the ways that the MCMC can assure/honor the participation of the approximately 700 stakeholders in this process so far. Overall, the Commission will take this work and elevate it in a way that is presentable to the Governor, either via letter, interim report, or guiding document.

Public Comments and Questions on Principles for MCM Step 2 Developed by the Commission

Commissioner Vallier-Kaplan opened the meeting for public comments and/or questions.

Public comment; not identified – Recommendation to divide the principles document into both refined principles and outcomes. Cultural competency and reading levels should also be considered.

Public comment; not identified – As a provider, principle #13 addresses quality, but suggests that this be #1. More specifically, that it not just be quality of care, but because recipients of LTSS receive such complex services it is quality of life. Transition to MCM should not directly or inadvertently impair quality of care or life. Second, it is suggested that any willing provider should be able to provide, especially in rural areas, without contract of MCMC services. Third, again, because of complex services provided to recipients and impact they have on their lives, any implementation of services for this population should go through a pilot program first. Also, administrative processes for all MCOs should be consistent in all major functions, e.g. claims process, eligibility. These should be aligned so providers are not dealing with multiple rules or sets of rules. Last, relative to managing the appeals process and borrowed from CMS, G&A process for LTSS recipients and providers should include accessible, knowledge, high-level liaisons that are familiar with this population. Liaisons should function as LTSS ombudsman where they reach out to individuals. Many who receive these services will not be capable of submitting a complaint. These items were also captured in a letter sent to the MCMC.

Public comment; not identified – An individual's history needs to be considered as a basic principle. An example is having bad experience with generic drugs. Individuals should not have to go in and recite this

to each provider. Also, to follow-up, suggest looking at language used particularly around issue in principle #8 related to employment. It should be more focused on purposeful living and quality life, as oppose to employment. For example, volunteer work should be supported for elders, not just young people.

Public Listening Session and Next Steps

Commissioner Vallier-Kaplan opens the meeting for public comments and questions.

Public comment; Able NH advocate – Many other providers are interested in attending the November meeting. If technology can be made available because of the distance, it will be crucial. Also, looking forward to future meetings, many advocates who also provide child care and employment wish to attend. The current meeting time from 1-4pm is challenging for family members who want to attend but cannot during business day. The Commission could consider having a meeting outside of business hours.

Public comment; Disability Rights Center – In terms of the grievance and appeals process, the Disability Rights Center receives a lot of calls from families who are navigating the process and run into subcontractors. Well Sense and NHHF both subcontract for some specialty services and families cannot navigate appeals process with these subcontractors. We will tell them to look at handbook; however, there is not a well-defined process for how to appeal within context of subcontractors. The appeal process has to go through subcontractors, not the actual MCO. We raise this for the record as an issue both in terms of information that needs to go out to indivuduals and systemic process problems between subcontractors and MCOs. We will continue to work with the MCOs to help iron out the issue.

Public comment; not identified – Thank you for all the hard work being done to try and address ongoing issues that are still being worked out while also trying to move forward with Step 2. We echo that creating a standard way of billing and things between both MCOs so service providers do not have to do multiple things is preferred. Smaller providers in rural areas are spending so much time in filing appeals, fighting them, figuring out who to talk to, etc. This is time that could be spent providing services. It is not a financially feasible business model to maintain. Anything to guide the MCOs or oversee them is appreciated.

Commissioner Vallier-Kaplan adjourned the meeting at 4:00pm.The next meeting of the MCMC will be held at White Mountain Community College in Berlin, NH from 1-4PM on November 6, 2014.

Follow-Up Items

The following items were noted as follow-up items during the October MCMC Meeting:

Key Performance Indicator (KPI) Report

1. Requested of DHHS to report out on the findings, if available, and/or agenda items of focus groups held in October with respect to the KPI report
2. DHHS to clarify if reference to "doctor" in description of measure on page 34 of the KPI actually means "provider" as presented to MCMC
    a. Note from MCMC: Referencing "provider" would be an achievement.
3. DHHS to review KPI finding that a low or falling number of follow-up appointments within 7 days indicates a successful discharge
    a. Note from MCMC: This places responsibility on hospital, but could also reflect lack of sufficient supports in community that result in readmission process
4. DHHS to review language within KPI and future presentations to focus more on care transitions instead of discharge planning

5. DHHS to prepare an update on the overall quality management system being created for a future presentation to the MCMC
6. DHHS to review current contract standards for quality to determine where/how benchmarks are set, e.g. whether they reflect national standards, best practices, or if they can be set to future improvement standards
7. DHHS to continue to review if benchmarks for certain measures can be set by current NH fee-for-service (FFS) metrics, as opposed to national industry standards

MCMC-Developed Principles for Step 2 MCM Feedback

1. Separate the legal parameters from the integrated system portion of principle #3 into two different principles, or add first portion of #3 to principle #9
2. Include care transitions language to principle #9
3. Determine a higher level of specificity and different name for the principles
    a. MCMC suggestion: Rename to reflect "implementation guidelines"
4. Consider an individual's history as a basic principle